

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS647HOS</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/03/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>HARMON MEDICAL AND REHABILITATION HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2170 EAST HARMON AVENUE LAS VEGAS, NV 89119</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Surveyor: 22046 This Statement of Deficiencies was generated as a result of a monitoring visit conducted in your facility on 12/2/09 and finalized on 12/3/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	S 000		
S 239 SS=E	<p>NAC 449.344 Administration of Medication</p> <p>2. Security of all medications must be maintained in accordance with applicable state law. This Regulation is not met as evidenced by: Surveyor: 22046 Based on observation and interview, the facility failed to secure medications in the crash cart on the 400 unit, failed to secure over the counter medications in a medication cart on 600 hall and left drawers of pre filled syringes containing Heparin and Saline unlocked on the 200 and 600 units.</p>	S 239		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 239	Continued From page 1  Severity: 1 Scope: 2	S 239			

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